STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001128	A. BUILDING: _____ B. WING _____	05/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDS FELLOWSHIP COMMUNITY	2030 CHESTER BLVD RICHMOND, IN 47374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Licensure Survey. Survey dates: May 16, 19 & 20, 2014 Facility Number: 001128 Provider Number: 001128 Survey team: Leslie Parrett RN, TC Barbara Gray RN Angel Tomlinson RN (May 19 & 20, 2014) Census bed type: Residential: 123 NCC: 54 Total: 177 Census payor type: Other: 177 Total: 177 Residential sample: 10 Friends Fellowship Community was found to be in compliance with 410 IAC 16.2 in regard to the State Licensure Survey. Quality Review 05/21/14 by Lisa McColly	R 000		